Tobacco Control 1997;6 (suppl 1):S1

PREFACE

The April 1996 release of the US Agency for Health Care Research (AHCPR) smoking cessation guideline was more than just the latest installment in an ongoing series of clinical practice guidelines. It was the culmination of a comprehensive effort to synthesise the tremendous breadth of smoking cessation research into a blueprint for universal intervention against smoking, which is the leading cause of preventable death and disease in America today. This issue of *Tobacco Control* contains the proceedings of a conference held on 17 and 18 September 1996 in Washington, DC, where researchers, clinicians, buyers, and policy makers discussed the implications of the release. As a document, the AHCPR guideline attempts to be definitive. But if it does not find its way into practice, its impact will be purely—and prematurely—historical.

We in the tobacco control field believe that smoking cessation is a valuable service we offer for the good of smokers, their friends and families, and Americans at large. Yet even smokers who want to quit (and most do)[1] may not embrace cessation as an unqualified good. If we treat the notion of tobacco addiction seriously, we must define it in terms that speak to the smoker's dilemma. Addiction is a disease, but many people suffering from tobacco addiction have only a distant and slightly unreal sense that they are not well; many would even consider themselves asymptomatic. This thinking is itself a symptom of addiction.

Several forces conspire to convince smokers that they are doing fine. The strongest of these is—of course—the tobacco industry. Looking at an advertisement Lorillard placed decades ago for its cigarette brand Old Gold (see cover), I have no sense of nostalgia; the mindset the advertisement panders to is alive and well today. "No old-hat medical claims . . . for a TREAT instead of a TREATMENT smoke OLD GOLD," the stylish smoker urges readers. As we better understand the mechanisms of nicotine delivery, we recognise what makes smoking seem like "a treat". Medical evidence disputing the joys of smoking is far less seductive than nicotine itself. Tobacco manufacturers have long succeeded in selling a product and selling it well. Unfortunately, that product satisfies consumers' expectation of it in that it feeds the very addiction it created.

We now can say with authority that the cigarette manufacturers were peddling addiction all along; their industry documents testify to their intentions. Still, people are willing to pay for addiction, because it offers them a perceived benefit (at least initially), be it escape, or euphoria, or image, or just a reliable routine of stimulus-response. Some are even willing to pay the social costs and side effects of addiction without complaint, although it is not clear that smokers appreciate the true scope of those costs. They can be considerably less sanguine about paying to be free of that addiction, especially if it is allowed by law and encouraged by a $6 billion outlay in advertising and promotion.

It seems inevitable that smoking cessation is understood in negative ways: smokers quit, cigarette breaks end, nicotine withdrawal begins. A tenet of pure science holds that it is impossible to disprove the negative; it is almost equally challenging to market it. Some smoking cessation regimens do better at casting cessation in positive terms, promoting what smokers will receive in return for their effort and outlay. They tout improved health, clean air, and an end to smoking-related risks and expenses—and rightly so. However, this message is still too weak and fragmented.

The question of who should pay remains in debate. We wrestled with just that issue in another conference held in Washington in 1993,[2] though it is painfully obvious that we all bear the costs of continued smoking. The central question of this conference is essentially a variation on the theme. Here we ask who—physicians, nurses, dentists, insurers, politicians, employers, community activists, or consumer advocates—should be on the sales team for cessation. If we want the demand for our product to exceed the demand for tobacco, we all should.

The release of the AHCPR guideline ensures that we will be drawing our cessation message from the same page of the same manual. Its impact derives from the impressive scope of its authorship and audience. Over several years, AHCPR involved dozens of experts in a national panel, enlisted more than 100 peer reviewers, and sought input from countless others. Its guideline offers a rational, science-based approach to smoking cessation interventions. It encourages every healthcare provider to identify smokers, urge them to quit smoking, and explain their cessation options. This should be a kind of guaranteed free advertising, even better than a doctor on television, because the doctor makes the pitch in person. How forceful a pitch remains at the discretion of the practitioner.

Yet the AHCPR guideline cannot be left in the hands of healthcare providers and administrators alone. Used fully, it should serve as a blueprint for healthcare policy as well as individual interventions. After all, it bears the imprimatur of a major governmental agency. In its advertisement for Old Gold cigarettes, Lorillard boasts, "No other leading cigarette is less irritating, or easier on the throat, or contains less nicotine than Old Gold. Who says this? Not Old Gold. This conclusion was established on evidence from the US Government."

In recent years, the US government has weighed in on the side of tobacco control as never before. Whatever the long-term implications of the FDA regulation of cigarettes as drug-delivery devices may be,[3] it represents one of the strongest anti-smoking messages the government has ever sent. In addition, FDA's 1996 switch of older nicotine replacement therapies to over-the-counter status and its pending approval of new prescription cessation products, guarantee consumers increasing opportunity to wean themselves of their dependence. In this environment, tobacco control activists have a good chance of seeing the AHCPR guideline widely disseminated and implemented—if they seize the moment.

This conference addresses a range of concerns, from managed-care approaches to implementing the AHCPR guideline, to incentives for employer-insurers promoting cessation, to collaborative initiatives starting in select communities. Bit by bit, these logistic negotiations make significant contributions to tobacco control. For years, we have bemoaned the advertising budget of Big Tobacco, its countless channels of promotion and sophisticated selling techniques. Our promotions may be more piecemeal and less well positioned, but we have a superior product in cessation. Now we have to convince smokers that cessation treatment is sweeter than tobacco addiction, and stronger.

JOHN M PINNEY

Pinney Associates, 4800 Montgomery Lane, Suite 1000, Bethesda, Maryland 20814-3433, USA

1 US Department of Health and Human Services. Cigarette smoking among adults—United States, 1993. *MMWR* 1994;**43**:925–9.
2 "Issues in smoking cessation: who quits? Who pays?" *Tobacco Control* 1993; **2**:suppl.
3 US Food and Drug Administration. Regulations restricting the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents. *Federal Register* 1996;**61**(28 Aug):44396–5318.